

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06912		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06910	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First Fritz	Middle (None)	Lost Anthony, Jr.	2a. DATE OF DEATH Month 7, Day 1969	
3. SEX Male			4. RACE White		5. DATE OF BIRTH Jan. 10, 1907		6. AGE (in years and birthday) 62 YRS.
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garr. Co. Mem. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Trackman	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W. Va. Grant			13b. CITY OR TOWN Bayard		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 10 Ash St.
14. FATHER'S NAME First Fritz			Middle Anthony		15. MOTHER'S MAIDEN NAME First Theresie		Middle Garnlupz
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-09-0459		17. INFORMANT Mrs. Fritz Anthony, Jr., Bayard, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> 2079 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <u>Emphysema</u> <u>Coronary heart failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 1964, to <u>May</u> , 1969, that (I) (we) last saw the deceased alive on <u>5-6-69</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>B. L. Grant</u>		DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 5/7/69	
22d. PHYSICIAN'S NAME (Type) Dr. B. L. Grant		22e. ADDRESS Oakland, Md. 21550					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 5/9/69		23c. NAME OF CEMETERY OR CREMATORY Bayard Cemetery		23d. LOCATION (City or Town and County) (State) Bayard, Preston, W. Va.	
24. FUNERAL DIRECTOR John O. Durst, Oakland, Maryland				25a. REC'D BY REGISTRAR DATE MAY 9 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00012

DATE: 1947 JAN 10 TIME: 10:00 AM

TO: Mr. J. Edgar Hoover, Director, FBI

FROM: Mr. [Name], [Title]

SUBJECT: [Subject]

RE: [Reference]

1. [Text]

2. [Text]

3. [Text]

4. [Text]

5. [Text]

6. [Text]

7. [Text]

8. [Text]

9. [Text]

10. [Text]

11. [Text]

12. [Text]

13. [Text]

14. [Text]

15. [Text]

16. [Text]

17. [Text]

18. [Text]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06913

CERTIFICATE OF DEATH

06911

1. DECEASED-NAME (Type or print) Charles Thomas Aultman			2a. DATE OF DEATH May 29 Day 1969			2b. HOUR 7:25 M					
3. SEX M		4. RACE W		5. DATE OF BIRTH May 11, 1886		6. AGE (In years last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett Md.					
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Machinist			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Garrett		13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last Thomas G. Aultman			15. MOTHER'S MAIDEN NAME First Middle Last Nancy --- Fordyce								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If give war or dates of service) 215-58-6962		17. INFORMANT Address Mrs. Letha Aultman, Friendsville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Acute Pulmonary Edema - Uremia DUE TO, OR AS A CONSEQUENCE OF (b) Cardio-Vascular Failure - Renal shutdown DUE TO, OR AS A CONSEQUENCE OF (c) Complete biliary obstruction - Metastatic Carcinoma. Primary tumor undetermined									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours 3 weeks Unknown		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Right hemi-paresis due to Cerebral Vascular Accident - 15 years duration											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 20, 1969, to May 29, 1969, that (I) (we) last saw the deceased alive on May 29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Kurt H. Leighton				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 29 May 1969			
22d. PHYSICIAN'S NAME (Type) Dr. H. Leighton				22e. ADDRESS Oakland, Md. 21550							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/1/69		23c. NAME OF CEMETERY OR CREMATORY Friendsville Cem.			23d. LOCATION (City or Town) (County) (State) Friendsville, Garrett, Md.				
24. FUNERAL DIRECTOR Kurt Neuman				ADDRESS Grantsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 5 1969		25b. REGISTRAR'S SIGNATURE Kurt Neuman			

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UNIVERSITY OF TEXAS

01430

RECEIVED
JAN 10 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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06914		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				06912	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
ARCHIBALD, WELLINGTON CONNELL				MAY 16 1969		6:40 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
MALE		WHITE		June 24, 1890		78 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		USA				GARRETT Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Oakland		Garrett Co. Mem. Hospital		Postmaster		Post Office	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		M Garrett		Hutton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.	
John Archibald Connell		Ella May Kirby		no		293-05-1354	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Miss Margaret Connell Phila., Pa.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lungs bilateral</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. LOCATION Street or R.F.D. No. City or Town County State		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1950 to 16 May 1969, that (I) (we) lost saw the deceased alive on 16 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>A. E. Mance</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 17 May 69		22d. PHYSICIAN'S NAME (Type) A. E. Mance	
22e. ADDRESS Oakland, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		5/19/69		Oakland Cemetery		Oakland, Maryland	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE	
Gerald D. Minnich		MAY 22 1969		Charles J. Jager		MAY 22 1969	

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VR 415 (4)
30M REV. 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
06915							06913		
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
HELEN BLANCHE DEVINE						MAY 6 1969			8:00 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		JULY 8, 1905		63 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Md.		USA				Garrett		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Oakland		Garrett Co. Memorial Hosp. - Housewife		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Garrett		Friendsville					
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John Wesley Schroyer			Amanda Jane Sweitzer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		---		Mrs. Amos Friend, Friendsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Massive Right Cerebral Hemorrhage									30 Hours
4122 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Cardio-Vascular Disease									10 years
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from October 1968, to May 6, 1969, that (I) (we) lost saw the deceased alive on May 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Herbert H. Leighton						6 May 1969			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Herbert H. Leighton, M.D.		Oak @ 5th Streets, Oakland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		5/10/69		St. Paul's Cemetery		Accident, Garrett, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Keith Newman		Grantsville, Md.		MAY 13 1969		[Signature]			

MEDICAL CERTIFICATION

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses.

2. The third part of the report is a description of the results of the study. This includes a description of the data collected, a description of the statistical analysis of the data, and a description of the experimental results. The fourth part of the report is a discussion of the results and their implications. This includes a discussion of the strengths and weaknesses of the study, a discussion of the limitations of the study, and a discussion of the implications of the results for future research.

3. The fifth part of the report is a conclusion. This includes a summary of the findings of the study, a statement of the conclusions drawn from the findings, and a statement of the recommendations for future research. The sixth part of the report is a list of references. This includes a list of the books, articles, and other sources used in the study.

4. The seventh part of the report is an appendix. This includes a list of the figures and tables used in the study, a list of the abbreviations used in the study, and a list of the symbols used in the study. The eighth part of the report is a list of the names of the people who contributed to the study. This includes a list of the names of the people who helped with the data collection, a list of the names of the people who helped with the statistical analysis, and a list of the names of the people who helped with the experimental procedures.

5. The ninth part of the report is a list of the names of the people who reviewed the report. This includes a list of the names of the people who reviewed the report for content, a list of the names of the people who reviewed the report for style, and a list of the names of the people who reviewed the report for grammar. The tenth part of the report is a list of the names of the people who approved the report. This includes a list of the names of the people who approved the report for publication, a list of the names of the people who approved the report for distribution, and a list of the names of the people who approved the report for archiving.

6. The eleventh part of the report is a list of the names of the people who funded the study. This includes a list of the names of the people who funded the study for the data collection, a list of the names of the people who funded the study for the statistical analysis, and a list of the names of the people who funded the study for the experimental procedures. The twelfth part of the report is a list of the names of the people who helped with the report. This includes a list of the names of the people who helped with the data collection, a list of the names of the people who helped with the statistical analysis, and a list of the names of the people who helped with the experimental procedures.

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4122

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06916

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06914

1. DECEASED-NAME (Type or print) First Middle Last Jennie Rebecca Ellifritz			2a. DATE OF DEATH Month Day Year May 21 1969			2b. HOUR 9:15 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 23, 1895		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign) Mineral Co. W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett Md.			
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life or, if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Kitzmilller		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Pee Wee Road	
14. FATHER'S NAME First Middle Last William - Puffenbarger			15. MOTHER'S MAIDEN NAME First Middle Last Julia F. Lewis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-014072B		17. INFORMANT Charles F. Ellifritz		Address Star Rt. Kitzmilller, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Pulmonary Edema</u> 4122 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 2 days years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1968, to 21 May 1969, that (I) (we) lost the deceased on 21 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. E. Mance M.D.				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 21 May 1969	
22d. PHYSICIAN'S NAME (Type) A. E. Mance, M.D.				22e. ADDRESS Oakland, Md. 21550					
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE May 24, 1969		23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		23d. LOCATION (City or Town) (County) (State) Elk Garden, Mineral Co. W. Va.			
24. FUNERAL DIRECTOR P. O. Kit zmilller, Md.				25a. REC'D BY REGISTRAR MAY 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

01000

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>06917</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06915</div>										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR	
Ida Flora Fratz						ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR			3 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
F	W	Jan. 16, 1889	80 YRS.	MONTHS	DAYS	HOURS	MIN.	Month 5 Day 8 Year 1969	11 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Md.		USA				Garrett Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Accident						Housewife			Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Garrett			Accident				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Solomon Glass			Anna Margroff							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
No			220-48-8777			Mrs. Erman Frazee, Accident, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4109</u>										
(b) <u>Arteriosclerosis, generalized</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Dibetes mellitus; old cerebral vascular accident</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. P.M.		19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED				
<i>James H. Feaster, Jr.</i>						5-8-69				
EXAMINER'S (NAME) (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)				
James H. Feaster, Jr., M. D.						Oak., Garr., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		5/11/69		Zion Church Cemetery		Accident, Garrett, Co., Md.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<i>Ruth Neuman</i>				Grantsville, Md.		MAY 13 1969		<i>Charles Judge</i>		

66917

RECEIVED LABORATORY DEPT. OF HEALTH

189

3 2
10

2-8-89

LABORATORY

hours

University Laboratory

years

and miscellaneous, general

subject matter; old general medical

2-8-89

Cal., Wash., Ind.

James H. Hester, Jr., M.D.

MAILED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06918

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06916

1. DECEASED-NAME (Type or Print)		First ORA		Middle (NMI)		Last LAMBERT		2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 5-1-69 19 1969			2b. HOUR 1145 P M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 22, 1892		6. AGE (In years lost birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 5 Day 1 Year 1969			2d. HOUR 1 P M
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett						Md.
10. CITY OR TOWN OF DEATH Rural-Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route #1,				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Coal Miner			12b. KIND OF BUSINESS OR INDUSTRY Soft Coal			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa.				13b. COUNTY Fayette		13c. CITY OR TOWN Point Marion		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rural Box 341,		
14. FATHER'S NAME First Middle Last Harvey Lambert				15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 224-12-4149		17. INFORMANT (Son) ADDRESS Pa. Brinley Lambert, Box 341, Point Marion,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Years												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 5-1-69				
EXAMINER'S (NAME) (Type) James H. Feaster, Jr., M. D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Oakland, Garr., Md.				
23a. BURIAL, CREMATION, BENEFIT (Specify)		23b. DATE May 4, 1969		23c. NAME OF CEMETERY OR CREMATORY Riverton Cemetery		23d. LOCATION (City or Town) (County) (State) Riverton, Pendleton, W. Va.						
24. FUNERAL DIRECTOR <i>John O. Durst</i> John O. Durst, Oakland, Maryland				25a. REC'D BY REGISTRAR DATE MAY 5 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

FOR STATE
HEALTH DEPT

00018

WEEKLY STATEMENT OF DEATH

00018

DATE	TIME	PLACE	CAUSE	AGE	SEX	RACE	RELATION	RESIDENCE	DEATH
May 1, 1968	10:30 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 2, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 3, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 4, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 5, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 6, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 7, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 8, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 9, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 10, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 11, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 12, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 13, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 14, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 15, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 16, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 17, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 18, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 19, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 20, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 21, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 22, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 23, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 24, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 25, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 26, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 27, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 28, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 29, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 30, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1
May 31, 1968	11:00 AM	Home	Heart Disease	75	M	W	Wife	1234 Main St, New York, NY	1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Marie		Middle Ann		Last Little		2a. DATE OF DEATH Month Day Year May 21 1969		
3. SEX Female			4. RACE White		5. DATE OF BIRTH Nov. 26, 1890		6. AGE (In years last birthday) 78 YRS.		2b. HOUR P 1:30 M		
7a. BIRTHPLACE (State or foreign country) Oakland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH GARRETT				10. CITY OR TOWN OF DEATH Oakland	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett Co. Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Typesetter		12b. KIND OF BUSINESS OR INDUSTRY Printing		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Oakland	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 709 E. Oak St.		14. FATHER'S NAME First Middle Last George David Little		15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Pfeiffer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 215-01-9076	
17. INFORMANT Address Alice Turney Oakland, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatoid Arthritis</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from Feb 1969, to 2/10/69, that (I) (we) last saw the deceased alive on 20 May 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE A. E. Mance M.D.	
22c. DATE SIGNED 2/10/69		22d. PHYSICIAN'S NAME (Type) A. E. Mance M.D.		22e. ADDRESS Oakland, Maryland 21550		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/24/69		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	
23d. LOCATION (City or Town) (County) (State) Oakland Maryland		24. FUNERAL DIRECTOR Gerald N. Minnick		ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE MAY 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE SIGNED	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06918

06920

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) Gilbert Troy Lowdermilk			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> Month 5 Day 8 Year 1969			2b. HOUR 10:45 A.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 2/26/1888	6. AGE (In years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month 5 Day 8 Year 1969		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH GARRETT		
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Star Route		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Garrett	13c. CITY OR TOWN Crellin	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last James Lowdermilk			15. MOTHER'S MAIDEN NAME First Middle Last Safronia DeWitt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 213-01-5646-A			17. INFORMANT ADDRESS Bessie Lowdermilk Crellin, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			5-8-69		
ADDRESS (Street, city, town, or county) Oakland, Garr., Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/10/69		23c. NAME OF CEMETERY OR CREMATORY Kisner Cemetery		23d. LOCATION (City or Town) (County) (State) Crellin, Maryland		
24. FUNERAL DIRECTOR <i>Gerald N. Minnich</i>				ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR MAY 13 1969		25b. REGISTRAR'S SIGNATURE <i>G. Charles Judge</i>

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